ASSURANT
Employee
Benefits

Group Benefits

The City of Falls Church

Long Term Disability
City Employee

CERTIFICATE OF
GROUP INSURANCE

Union Security Insurance Company certifies that the insurance stated in this Certificate became effective on the Effective Date shown in your Schedule. This Certificate is subject to the provisions of the below numbered *policy* issued by Union Security Insurance Company to the *policyholder*.

Policyholder: The City of Falls Church

Group Policy Number: 4,027,243

Participation Number: 0

Type of Coverage:

Group Long Term Disability Insurance

This Certificate replaces any and all Certificates and Certificate Endorsements, if any, issued to you under the *policy*.

Michael J Peninger

Executive Vice-President

SCHEDULE

Eligible Persons

To be eligible for insurance, a person must be a member of an Eligible Class. The person must also complete a period of continuous service (Service Requirement) with the *policyholder* (or any *associated company*).

Eligible Class: Each *full-time* city employee of the *policyholder* or an *associated company*,

- who is at *active work*, and
- who is working in the United States of America,

except any temporary or seasonal worker.

Associated Companies: The City of Falls Church Schools

Service Requirement: None

Entry Date

Insurance will take effect on the later of (i) the date shown below, and (ii) the first of the month occurring on or after the day all the eligibility requirements are met.

Effective Date of Insurance

For *periods of disability* starting on or after July 1, 2002 (subject to Entry Date)

Long Term Disability Insurance

Schedule Amount: 60% of *monthly pay* subject to a maximum Schedule Amount of $5,000 per month, except as stated in Proof of Loss provision.

For each day of a period less than a full month, the Schedule Amount will be 1/30th of the amount determined above.

SCHEDULE (continued)

Monthly pay means your basic monthly pay from the *policyholder* or an *associated company*, and is determined on the day before the *period of disability* starts. Bonuses, overtime, and other compensation not considered by us as basic wages or salary are not included. However, a monthly average of any commissions received during the prior full calendar year will be included. If you have been eligible to receive commissions for less than a full calendar year, *monthly pay* will include a monthly average of commissions received during the time you were eligible to receive them.

If you are an hourly employee, *monthly pay* will be based on your hourly rate of pay, but not on more than 40 hours per week.

Minimum Benefit: If you normally work at least 30 hours per week before your *period of disability* starts, the minimum monthly benefit will be $100. For any part of a *period of disability* less than a full month, the Minimum Benefit is 1/30th of $100 for each day of *disability* after the *qualifying period* ends.

Qualifying Period: 120 days

Maximum Interruption During Qualifying Period: 20 days

This Maximum applies to all returns to *active work* during any one *qualifying period.*

Maximum Amount Without Proof of Good Health: The maximum amount of insurance for which a *covered person* can become insured without furnishing *proof of good health* is $5,000.

Monthly Payment Limit: 70% of *monthly pay*

Maximum Benefit Period: We will not pay benefits beyond the maximums stated below, based on the person's age on the day the *period of disability* started.

Age	Maximum Benefit Period
Before 60	the day before retirement age*
60 but before 65	the day before retirement age* or 36 months of *disability***, whichever is longer
65 but before 68	24 months of *disability***

SCHEDULE (continued)

68 but before 70	18 months of *disability* **
70 but before 72	15 months of *disability* **
72 or more	12 months of *disability* **

*"Retirement age" means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act.

**following the end of the *qualifying period*.

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GENERAL DEFINITIONS

These terms have the meanings shown here when *italicized*. The pronouns "we", "us", "our", "you", and "your" are not *italicized*.

Active work means the expenditure of time and energy for the *policyholder* or an *associated company* at your usual place of business on a *full-time* basis. If you are working on the day your coverage would otherwise take effect, you will be considered to be at *active work* on that day only if, when your work begins on that day, it would be reasonable to expect that you would be physically and mentally able to complete a *full-time* week of work in your *regular occupation*.

Associated company means any company shown in the *policy* which is owned by or affiliated with the *policyholder*.

Contributory means you pay part of the premium.

Covered person means an eligible employee or member of the *policyholder*, or an *associated company* who has become insured for a coverage.

Doctor means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. Also, a person whom we are required to recognize as a *doctor* by the laws or regulations of the governing jurisdiction, or a person who is legally licensed to practice psychiatry, psychology or psychotherapy and whose primary work activities involve the care of patients, is a *doctor*. However, neither you nor a *family member* will be considered a *doctor*.

Eligible class means a class of persons eligible for insurance under the *policy*. This class is based on employment or membership in a group.

Family member means a person who is a parent, spouse, child, sibling, domestic partner, grandparent or grandchild of the *covered person*.

Full-time means working at least 37.5 hours per week, unless indicated otherwise in the *policy*.

Home office includes our Home Office located in St. Paul, Minnesota, and our office in Kansas City, Missouri.

Injury means accidental bodily injury. It does not mean intentionally self-inflicted injury while sane or insane.

GENERAL DEFINITIONS (continued)

No-fault motor vehicle coverage means a motor vehicle plan that pays disability or medical benefits without considering who was at fault in any accident that occurs.

Noncontributory means the *policyholder* pays the premium.

Policy means the group policy issued by us to the *policyholder* that describes the benefits for which you may be eligible.

Policyholder means the entity to whom the *policy* is issued.

Proof of good health means evidence acceptable to us of the good health of a person.

We, us, and our mean Union Security Insurance Company.

You and your mean an employee or member of the *policyholder* or an *associated company* who has met all the eligibility requirements for a coverage.

DEFINITIONS FOR LONG TERM DISABILITY INSURANCE

Accommodation expense means the costs your employer incurs to accommodate your *disability*, as required by the Americans with Disabilities Act or similar legislation. It also means costs you incur for tools, equipment, furniture, computer software, or other items necessary for you to return to work. The amount of the *accommodation expense* will be limited to $3,000 for each *period of disability*.

Appropriate medical plan means either an appropriate plan to arrive at a more accurate or more supported diagnosis of your medical condition(s), or an appropriate plan of treatment of your medical condition(s), or both.

Disability or *disabled* means that in a particular month, you satisfy either the Occupation Test or the Earnings Test, as described below. You may satisfy both the Occupation Test and Earnings Test, but you need only satisfy one Test to be considered *disabled*.

Occupation Test

- during the first 24 months of a *period of disability* (including the *qualifying period*), an *injury*, sickness, or pregnancy requires that you be under the *regular care and attendance* of a *doctor*, and prevents you from performing at least one of the *material duties* of your *regular occupation*; and

- after 24 months of *disability*, an *injury*, sickness, or pregnancy prevents you from performing at least one of the *material duties* of each *gainful occupation* for which your education, training, and experience qualifies you.

If, during the first 24 months of a *period of disability* (including the *qualifying period*), you can perform the *material duties* of your *regular occupation* with *reasonable accommodation(s)*, you will not be considered *disabled*. If, after 24 months of a *period of disability*, you can perform a *gainful occupation* for which your education, training, and experience qualifies you, with *reasonable accommodations(s)*, you will not be considered *disabled*. The inability to perform a *material duty* because of the discontinuance of *reasonable accommodation(s)* on the part of the employer does not, in itself, constitute *disability*.

Earnings Test

You may be considered *disabled* in any month in which you are actually working, if an *injury*, sickness, or pregnancy, whether past or present, prevents you from earning more than 80% of your *indexed monthly pay* in that month in any *occupation* for which your education, training or experience qualifies you. On each anniversary of the date your *disability* started, we will use your *indexed monthly pay* to decide whether you are *disabled* under this test.

If your actual earnings during any month are more than 80% of your *indexed monthly pay* you will not be considered *disabled* under the Earnings Test during that month. In making this determination, salary, wages, partnership or proprietorship draw, commissions, bonuses, or similar pay, and any other income you receive or are entitled to receive will be included. However, sick pay and salary continuance for periods not at work will not be included. Any lump sum payment will be pro-rated, based on the time over which it accrued or the period for which it was paid.

If you are capable of earning more than 80% of your *indexed monthly pay*, you will not be considered *disabled* under the Earnings Test even if your actual earnings in that month are less than 80% of your *indexed monthly pay*.

You may still be considered *disabled* according to the Occupation Test, without regard to your level of current earnings, if you meet the requirements of that Test.

you meet the Earnings Test, *full-time* work in which you are erforming all of the *material duties* of your *regular occupation* or some ther *occupation* will not interrupt the *qualifying period* or the *period of sability*. If you meet the Occupation Test only, work on less than a *ll-time* basis or work in which you are not doing all of the *material ties* of your *regular occupation*, will not interrupt the *qualifying period* the *period of disability*.

lucation expense means, in your *rehabilitation plan*, the reasonable sts you incur which are required for your education or training to turn to work. These costs may include the cost of tuition, books, mputers, and other equipment. In your spouse's *rehabilitation plan*, *ucation expense* means the reasonable costs your spouse incurs

which are required for your spouse's education or training. These costs may include the cost of tuition, books, computers, and other equipment.

Family care expense means the amount you spend for care of a family member in order for you to work or be retrained under a *rehabilitation plan*. To qualify:

- your family member must be under age 13, or be physically or mentally incapable of caring for him or herself;
- your family member must be dependent on you for support and maintenance; and
- the person who cares for your family member cannot be a relative.

Not more than $350 per family member per month will be included. A pro-rated amount will apply to any period shorter than a month.

Gainful occupation means an *occupation* in which you could reasonably be expected to earn at least as much as your Schedule Amount within 12 months of your return to work.

Government plan means the United States Social Security Act, the Railroad Retirement Act, the Canadian Pension Plan, similar plans provided under the laws of other nations, and any plan provided under the laws of a state, province, or other political subdivision. It also includes any public employee retirement plan or any teachers' employment retirement plan, or any plan provided as an alternative to any of the above acts or plans. It does not include any Workers' Compensation Act or similar law, or the Maritime Doctrine of Maintenance, Wages, or Cure.

Hospital means a facility supervised by 1 or more *doctors* and operated under state and local laws. It must have 24-hour nursing service by registered graduate nurses. It may specialize in treating alcoholism, drug addiction, chemical dependency, or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged.

Hospital confined and *hospital confinement* mean staying in a *hospital* for 24 hours a day.

Indexed monthly pay means your *monthly pay* increased by 7.5% on each anniversary of the date your *disability* started.

DEFINITIONS FOR LONG TERM DISABILITY INSURANCE (continued)

Long term disability insurance means the group long term disability insurance under the *policy* issued by us to the *policyholder*.

Material duty or material duties mean the sets of tasks or skills required generally by employers from those engaged in an *occupation*, which cannot be reasonably accommodated. We will consider one *material duty* of your *regular occupation* to be the ability to work for an employer on a *full-time* basis as defined in the *policy*. However, if a *material duty* of your *regular occupation* is to work more than 40 hours per week, we will consider you able to perform that *material duty* if you have the capacity to work at least 75% of those hours per week. In addition, no duty will be considered a *material duty* of your *regular occupation* if you were not able, as a result of *injury*, sickness, or pregnancy, to perform that duty with reasonable consistency at the time you became a *covered person* or entered that *occupation*, if later.

Medical expense means the reasonable costs you incur for medical treatment, physical therapy, and adaptive equipment necessary for your vocational rehabilitation, in excess of amounts paid or payable by third parties and any amounts under a policy of major medical coverage.

Mental illness means a mental disorder as listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association. A *mental illness*, as so defined, may be related to or be caused by physical or biological factors, or result in physical symptoms or expressions. For the purposes of the *policy*, *mental illness* does not include any mental disorder listed within any of the following categories found in the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association:

- Mental Retardation;
- Motor Skills Disorder;
- Pervasive Developmental Disorders;
- Delirium, Dementia, and Amnestic and other Cognitive Disorders;
- Schizophrenia; and
- Narcolepsy, Obstructive Sleep Apnea, and Sleep Disorder due to a general medical condition.

DEFINITIONS FOR LONG TERM DISABILITY INSURANCE (continued)

Moving expense means the costs you incur to move more than 35 miles so that you can attend school or accept gainful work. In a spouse's *rehabilitation plan*, the costs are those incurred by the family so that the spouse can attend school or accept gainful work.

Nationally recognized authorities means the American Medical Association (AMA), the AMA Board of Medical Specialties, the American College of Physicians and Surgeons, the Food and Drug Administration, the Centers for Disease Control, the Office of Technology Assessment, the National Institutes of Health, the Health Care Finance Administration, the Agency for Health Care Policy and Research, the Department of Health and Human Services, the National Cancer Institute, the American Psychiatric Association, and any additional organizations we choose which attain similar status.

Occupation means a group of jobs:

- in which a common set of tasks is performed; or
- which are related in terms of similar objectives and methodologies, and which may be related in terms of materials, products, worker actions, or worker characteristics.

Other plan means any group disability plan sponsored by your employer, the *policyholder*, or an *associated company*, except the one provided under the *policy*.

Period of disability means the time that begins on the day you become *disabled* and ends on the day before you return to *active work*. If you satisfy the *qualifying period* and then:

- return to *active work*;
- become *disabled* again; and
- remain insured under the *policy*;

the same *period of disability* may continue. Your return to *active work* must be for less than:

- 6 months, if the later *disability* results from the same cause, or a related one; or

- 1 day, if the later *disability* results from a different cause.

If your return to *active work* meets either of the above conditions, you do not have to satisfy the *qualifying period* again. The Maximum Benefit Period will continue on the day you become *disabled* again.

If you return to *active work* for more than the time shown above, and then become *disabled* again, you will start a new *period of disability*. You must satisfy the *qualifying period* again and the Maximum Benefit Period will start over.

Qualifying period means the length of time during a *period of disability* that you must be *disabled* before benefits are payable. If you satisfy the Earnings Test during the entire *qualifying period*, the Maximum Interruption During Qualifying Period in the Schedule will not apply. If application of the Occupation Test and the Maximum Interruption During Qualifying Period would result in an earlier entitlement to benefits, we will apply those provisions instead of the Earnings Test. In satisfying the Occupation Test, if you:

- return to *active work* during the *qualifying period* for no more than the maximum number of days shown in the Schedule;

- remain insured under the *policy*; and

- become *disabled* again for the same cause or one related to it;

you will not have to satisfy again the part of the *qualifying period* that you have already fulfilled.

In any case, you cannot satisfy any part of the *qualifying period* by any *period of disability* that results from a cause for which we do not pay benefits.

Any days of *active work* (including weekends in between) will not count in satisfying the *qualifying period*.

Quality of care services means services which are designed to assist you in reaching and maintaining the functional capacity to work in a *gainful occupation* with reasonable continuity.

Reasonable accommodation(s) means any modification(s) to the worksite, the job or employment practices, which would allow you to perform the *material duties* of the *occupation* and which would not create an undue hardship for the employer.

Regular care and attendance means care by a *doctor* at a frequency medically appropriate for your condition. If your condition does not require frequent visits to your *doctor*, neither will we.

Regular occupation means the *occupation* in which you were working immediately prior to becoming *disabled*.

Rehabilitation plan means a written statement, developed by us, which describes:

- the vocational rehabilitation goals for you;

- our responsibilities, your responsibilities, and the responsibilities of any other parties to the plan; and

- the timing of the implementation and expected completion of the plan, to the extent that it can be established, assuming your full cooperation.

The *rehabilitation plan* will be designed to enable you to return to work in a *gainful occupation*.

A spouse's *rehabilitation plan* means a written agreement between you, your spouse, and us in which, at your request, we agree to provide, arrange or authorize appropriate vocational or physical rehabilitation services.

Retirement plan means a formal or informal retirement plan, whether or not under an insurance or annuity contract. It does not include:

- a plan you pay for entirely;

- a qualified profit-sharing plan;

- a thrift plan;

- an individual retirement account (IRA);

- a tax sheltered annuity (TSA);

DEFINITIONS FOR LONG TERM DISABILITY INSURANCE (continued)

- a stock ownership plan;
- a *government plan*; or
- a plan that qualifies under Internal Revenue Service Code 401(k).

Social security plan means:

- the United States Social Security Act;
- the Railroad Retirement Act;
- the Canadian Pension Plan; or
- any similar plan provided under the laws of any other nation.

It also means any public employee retirement plan, or teachers' employment retirement plan provided as an alternative to rather than a supplement for such plans.

SSA representatives are persons or organizations which specialize in assisting people to obtain disability benefits under the United States Social Security Act. If you appoint an *SSA representative*, and they agree you are a good candidate, they will help you pursue your Social Security claim.

Special conditions means:

- *mental illness*;
- musculoskeletal and connective tissue disorders of the neck and back including any disease or disorder of the cervical, thoracic and lumbosacral back and its surrounding soft tissue including sprains and strains of joints and adjacent muscles, except
  - arthritis;
  - ruptured intervertebral discs;
  - scoliosis;
  - spinal fractures;

DEFINITIONS FOR LONG TERM DISABILITY INSURANCE (continued)

  - osteopathies;
  - spinal tumors, malignancy, or vascular malformations;
  - radiculopathies, documented by electromyogram;
  - spondylolisthesis, grade II or higher;
  - myelopathies and myelitis;
  - demyelinating diseases; or
  - traumatic spinal cord necrosis.
- chronic fatigue syndrome;
- fibromyalgia;
- carpal tunnel syndrome;
- environmental allergic illness, including but not limited to sick building syndrome and multiple chemical sensitivity; or
- alcohol, drug or chemical abuse, dependency or addiction.

ELIGIBILITY AND TERMINATION PROVISIONS

Exception to Effective Date

If you are not at *active work* on the day you would otherwise become insured, your insurance will not take effect until you return to *active work*. If the day your coverage would normally take effect is not a regular work day for you, your coverage will take effect on that day if you are able to do your regular job.

When Your Insurance Ends

Your insurance will end on the date:

- the *policy* ends;
- the *policy* is changed to end the insurance for your *eligible class*;
- you are no longer in an *eligible class*;
- you stop *active work*; or
- a required contribution was not paid.

LONG TERM DISABILITY INSURANCE

Insurance Provided

If you become *disabled* while insured under the *policy*, we will pay long term disability benefits if you satisfy the *qualifying period*. We will continue to pay benefits during your *disability*, but not beyond the Maximum Benefit Period. Any benefits are subject to the provisions of the *policy*.

Amount of Benefit

The amount of benefit we will pay is the lesser of:

- the Schedule Amount minus the Offset Amount; or
- the Monthly Payment Limit minus the sum of the Offset Amount and the Other Sources.

However, we will not pay less than the Minimum Benefit.

Offset Amount

If you are eligible for any of the following benefits or other amounts, the total of all monthly benefits and other amounts plus the pro-rated amount of any lump sum payments will be subtracted from the Schedule Amount:

- group disability benefits from any *other plan*.
- disability benefits from the United States Social Security Act, including dependent benefits, payable because of your *injury*, sickness, or pregnancy.
- disability benefits from a *government plan*, except Social Security.
- any benefits (except medical or death benefits) or any amount received in a settlement or compromise of your rights, under:
    - any Workers' Compensation Act (or a similar law); or
    - the Maritime Doctrine of Maintenance, Wages or Cure.

- retirement benefits from the United States Social Security Act unless your *disability* begins after age 65 and you were already receiving such retirement benefits.

- retirement benefits, disability benefits, or similar benefits (not including your contributions) from a *retirement plan* sponsored by your employer, the *policyholder*, or an *associated company*.

  We will not consider any amounts rolled over or transferred into any eligible retirement plan unless such amounts are subsequently withdrawn during the Maximum Benefit Period, at which time we will subtract such amounts retroactively without regard to any other provisions of the *policy*.

  Early retirement benefits from a *retirement plan* will be included only if:

  - you choose to receive them; or
  - they would not reduce the normal retirement benefit under the *retirement plan* sponsored by your employer.

- any amount you receive (including any amount you received in a settlement or compromise) because of a claim for any of the sources listed in the Offset Amount.

- retirement benefits from a *government plan*.

Other Sources

- If you are eligible to receive any salary, wages, partnership or proprietorship draw, commissions, or similar pay from any work you do, we will not consider such income for the 12 consecutive months starting on the day you become entitled to it, as long as the sum of:

  - the income described above,
  - the Schedule Amount, and

  - benefits from any source described in Other Sources,

  is not more than 100% of your *monthly pay*. If the sum is more than 100% of your *monthly pay*, we will subtract the amount over 100% from the Schedule Amount when determining your benefit under the *policy*.

  After 12 months, we will consider 70% of the amount determined after reducing any salary, wages, partnership or proprietorship draw, commissions or similar pay you are eligible to receive from any work you do, by any *family care expense*.

- any amount you receive of a type included in your *monthly pay* for the purpose of determining your *long term disability insurance* benefit under the *policy*.

- any amount you receive (including any amount you received in a settlement or compromise) because of a claim for any of the sources listed in the Other Sources.

- any group disability insurance contract, except one sponsored by your employer, the *policyholder*, or an *associated company*.

- any *no-fault motor vehicle coverage*, unless:

  - state law or regulation does not allow group disability benefits to be reduced by benefits from *no-fault motor vehicle coverage*; or
  - the *no-fault motor vehicle coverage* determines its benefits after benefits have been paid under the *policy*; or
  - the benefits are provided under optional coverage.

Estimate of Benefits or Other Amounts

If:

- you are eligible for benefits or other amounts from any of the above sources; or

- it is reasonable to believe that you would be paid such benefits or other amounts if you had applied for them or had applied for them on time;

we will figure your monthly benefit as though you are receiving these other benefits or amounts, even if you are not.

We will:

- estimate the amount of your Social Security benefit; and

- offset that amount as described above;

until we receive notice of a denial of such benefits at the first level of appeal after an initial denial.

We will adjust your monthly benefit when we receive proof that such benefits or other amounts are not payable or are denied.

Social Security Assistance

Your claim for Social Security disability benefits may be denied up to the reconsideration level. If it is, we will have it reviewed by an *SSA representative*, at your request.

If we consider you a good candidate, we will start this process. We will give you a list of *SSA representatives*. If you choose from this list, we will pay their fee.

Whether you use our help or not, we will reimburse you for the fee charged you by your *SSA representative*. In order to obtain this reimbursement, you must become entitled to Social Security disability benefits while eligible for benefits under our *policy*. If you are no longer eligible for benefits under the *policy* but then become entitled to Social Security disability benefits retroactive to a date while you were still eligible for benefits under the *policy*, we will reimburse you for the fee charged you by an *SSA representative*. Our reimbursement is limited to the fee approved by the Social Security Administration. We may reduce any overpayment calculated in our claim.

Adjustment of Benefits

If we find that the amount of benefit which we should have paid is different from the amount of benefit we actually paid you, we will adjust your benefit.

If we paid you less than we should have, we will pay you the difference.

If we paid you more than we should have, you must reimburse us. Any future benefits we determine to be due, including the Minimum Benefit, will be applied to the overpayment until we are reimbursed in full.

Lump Sum Benefit

If you receive benefits from any source in a lump sum, we will pro-rate it over the time in which it accrued, based on information from the source of the payment. If we do not receive all the information we need, we will pro-rate the payment according to its nature and purpose.

Benefit Freeze

We will not reduce your monthly benefit further if the amount of benefits from any source, other than the *policy*, changes because of a cost of living increase that occurs automatically or by law after you satisfy the *qualifying period*.

Managed Rehabilitation Benefit

Rehabilitation Plan for You

You may be eligible to receive vocational rehabilitation services. In order to be eligible for such services you must have the functional capability to successfully complete a *rehabilitation plan*.

Vocational rehabilitation services will include the preparation of a *rehabilitation plan* for you, with input from you and your *doctor*. We, you, your *doctor*, or your employer can begin the process of developing a *rehabilitation plan*. Vocational rehabilitation services may include, at our sole discretion, payment of your *medical expense*, *education expense*, *moving expense*, *accommodation expense*, or *family care expense*.

While you are participating, with your full cooperation, in your *rehabilitation plan*, we will increase your Schedule Amount by 10% of your *monthly pay* or $1,000, whichever is less. During

this period, your Schedule Amount may exceed the maximum Schedule Amount in the Schedule.

If you return to work as part of a *rehabilitation plan* while you are *disabled*, we will pay your employer:

- 100% of your salary, wages, partnership or proprietorship draw, commissions, or similar pay; or
- the Schedule Amount, if less;

for the first month after you return to work, or your remaining *period of disability*, if less.

If your *disability* ends while you are participating, with your full cooperation, in your *rehabilitation plan*, and you are not able to find gainful work, we will:

- pay you the amount of benefit, other than rehabilitation benefits, that would have been payable to you if you had remained *disabled* until:
  - 3 months after your *disability* ends; or
  - the date you are able to find gainful work, if earlier; and
- provide or pay for reasonable job placement services for a period of up to 3 months after your *disability* ends.

Failure to participate with your full cooperation in the *rehabilitation plan*, without good cause, will result in the reduction or the end of your *long term disability insurance* benefits. If benefits end, your *long term disability insurance* coverage under the *policy* will end. Reduction of benefits will be based on your projected income if you had met the goals of the *rehabilitation plan*. Benefits will be figured as though you were:

- actually working in the *occupation* contemplated in the *rehabilitation plan*; and
- earning the projected income amount.

If such work at the projected income amount would have resulted in the end of your *long term disability insurance*

benefits, your benefits will end as of the expected completion of the *rehabilitation plan*. "Good cause" means a medical reason preventing implementation of the *rehabilitation plan*.

We will make the final determination of any vocational rehabilitation services provided, of your eligibility for participation, and of any continued benefit payments.

Rehabilitation Plan for Your Spouse

You and your spouse may ask to participate in a *rehabilitation plan* for your spouse while you are *disabled* if:

- you are receiving disability benefits from a *social security plan*; and
- your spouse's earnings in the six calendar months prior to your *disability* averaged less than 60% of your *monthly pay*.

We have the sole discretion to approve or deny your request. The terms and conditions of the *rehabilitation plan* must be mutually agreed by you, your spouse, and us.

The *rehabilitation plan* for your spouse may include, at our discretion, payment of your spouse's *education expense*, reasonable job placement expenses, and the family's *moving expense*, if any. It may also include *family care expense* incurred by your spouse, necessary in order for your spouse to be retrained under the *rehabilitation plan*.

We will reduce the amount of your benefit we pay you by 50% of any salary, wages, partnership or proprietorship draw, commissions, or similar pay from any work your spouse does as a result of participating in your spouse's *rehabilitation plan*. If your spouse is working when your spouse's *rehabilitation plan* begins, we will only reduce your benefit by 50% of the increase in income that results from your spouse's participation in your spouse's *rehabilitation plan*.

Quality of Care Benefit

You may be eligible for *quality of care services*, while you are *disabled*. *Quality of care services* will be provided at our sole discretion. In providing *quality of care services*, we will help develop an *appropriate medical plan* for you. As part of the *appropriate medical plan*, we may:

- arrange any necessary second medical opinions or specialty consultations;
- recommend referral to therapeutic programs including, but not limited to, physical therapy, occupational therapy, speech therapy, exercise programs, mental health programs, pain clinic programs, and other medical rehabilitation programs;
- identify durable medical equipment which might improve your ability to function;
- provide published medical materials for you or your *doctor*, and refer you to support groups for people with similar impairments;
- negotiate discounts for your benefit with providers of medical services, equipment, or prescription drugs;
- help you identify third parties who may pay for needed therapeutic programs, equipment, or services; or
- pay for reasonable costs you incur to participate in the plan, in excess of amounts paid or payable by third parties (including any amounts receivable under a policy of medical coverage). We may pay for such costs if you would not otherwise be able to undertake the necessary therapeutic program or receive the services. We will consider, among other things, the likelihood that such programs or services will result in an overall lowering of benefits payable to you under the *policy*.

If we find that an *appropriate medical plan* for your condition has not yet been developed for you, we will develop and endorse such a plan, with input from you and your *doctor*. If we find that your *doctor* has devised an *appropriate medical plan* for you, but you have not followed that plan consistently, we will endorse that plan. In making our decision to endorse a plan, we will rely on the currently published guidelines with respect to your medical condition from *nationally recognized authorities*. If more than one *appropriate medical plan* exists, you and your *doctor* may choose the one most appropriate for you.

Long term disability insurance benefits and your coverage under the *policy* will both end, without regard for any other provisions of the *policy*, if:

- there is unreasonable failure on your part to undergo a scheduled examination for a second medical opinion or specialty consultation; or
- once we have endorsed an *appropriate medical plan* for you, you fail to comply with this plan without good cause. "Good cause" means a medical reason preventing implementation of the plan.

We will make the final determination of any *quality of care services* provided, of your eligibility for participation, and of any continued benefit payments.

Exclusions

We will not pay benefits for any time you are confined to any facility because you were convicted of a crime or public offense.

We will not pay benefits for any *disability* caused by:

- war or any act of war, whether declared or not;
- intentionally self-inflicted injury, while sane or insane; or
- taking part in or the result of taking part in committing an assault or felony.

We will not pay benefits if:

- your employer, the *policyholder*, or an *associated company* has offered you the opportunity to return to limited work while you are *disabled*;
- you are functionally capable of performing the limited work which is offered; and
- you do not return to work when and as scheduled.

Benefits will end as of the date you were first scheduled to return to work. Subject to the terms of the *policy*, benefits will recommence on the earlier of the date you return to such work, if you remain *disabled*,

or the date your *disability* worsens so that you are no longer capable of such work.

Special Conditions

We pay only a limited benefit for a *period of disability* due to *special conditions*. The Maximum Benefit Period for all such *periods of disability* is 24 months. This is not a separate maximum for each such condition, or for each *period of disability*, but a combined maximum for all *periods of disability* and for all of these conditions.

Your *period of disability* will be considered due to *special conditions* if:

- you are limited by one or more of the stated conditions; and
- you do not have other conditions which, in the absence of the stated conditions, would continue to exist, limit your activities, and lead us to conclude that you were *disabled*.

Benefits may be payable for more than 24 months, but not beyond the Maximum Benefit Period in the Schedule, if you

- are *hospital confined* at the end of the 24-month period above, and
- remain *disabled*.

Benefits will be payable for the length of your confinement and for up to 60 days following the end of your confinement.

If you are *hospital confined* again during the 60-day period for at least 10 consecutive days, benefits will be payable for the length of the second confinement and for up to 60 days following the end of the second confinement.

Pre-Existing Conditions

We will not pay benefits for any *disability* resulting, directly or indirectly, from a pre-existing condition (defined below) unless the *disability* begins after the earlier of:

- 3 consecutive months, ending on or after the day you became insured under the *long term disability insurance policy*, during which you do not consult with

or receive advice from a licensed medical or dental practitioner or receive medical or dental care, treatment or services, including taking drugs, medicine, insulin, or similar substances, for that condition; or

- 12 consecutive months during which you are continuously insured under the *long term disability insurance policy*.

A "pre-existing condition" means an *injury*, sickness, pregnancy, symptom or physical finding, or any related *injury*, sickness, pregnancy, symptom or physical finding, for which you:

- consulted with or received advice from a licensed medical or dental practitioner; or
- received medical or dental care, treatment, or services, including taking drugs, medicine, insulin, or similar substances

during the 3 months that end on the day before you became insured under the *long term disability insurance policy*.

If your *disability* results from more than one condition, we will determine whether you would be *disabled* in the absence of all pre-existing conditions. If we conclude that you are *disabled* by one or more conditions which are not pre-existing conditions, we will consider your claim as not resulting from a pre-existing condition for so long as this remains true.

Extended Benefit

If you are *disabled* on the day your *long term disability insurance* ends, and if you remain *disabled* long enough to qualify, we will pay benefits according to the *policy*.

Conversion Privilege

If your *long term disability insurance* ends, you may be able to convert to coverage provided under a conversion policy. You must have been insured under the *policy* for at least a year. This includes time insured under any similar group policy which the *policy* replaces.

Within 31 days after your insurance ends, you must:

- apply for coverage under the conversion policy; and

- pay the first premium.

Proof of good health is not required.

You cannot convert if your *long term disability insurance* ends because:

- the *policy* ends;
- the *policy* is changed to end your coverage;
- you are *disabled*;
- a required premium is not paid; or
- you retire from your employer, the *policyholder*, or an *associated company*.

The benefits of the conversion policy will be those we offer for conversion at the time you apply. The premium will be based on rates in effect for conversion policies at that time. The effective date of coverage will be the day after your insurance under the *policy* ends.

Survivor Benefit

If you die while entitled to benefits under the *policy*, we will pay a survivor benefit. We must receive proof of your death and proof that the person claiming the benefit is entitled to it. We will pay the survivor benefit only to your lawful spouse, if living, otherwise, to your children. Children must be unmarried, and under age 21 or, if a full-time student, age 25. "Children" include step-children or foster children that depended on you for support and maintenance. Adopted children are also included.

The monthly survivor benefit equals the monthly benefit payable under the *policy* for your last full calendar month of *disability*. If no benefit was paid for a full calendar month, a survivor benefit for a full month will be determined.

The survivor benefit is payable on:

- the first of the month after your death; and
- the first of each of the next 2 months.

If no one entitled to the survivor benefit is living on the first of any month after your death, we will pay a survivor benefit to your estate.

Payment of the survivor benefit is subject to the other provisions of the *policy*.

CLAIM PROVISIONS

Payment of Benefits

We will pay benefits at the end of each month (or shorter period) for which we are liable, after we receive the required proof. If any amount is unpaid when *disability* ends, we will pay it when we receive the required proof.

To Whom Payable

We will pay all benefits to you. However, if medical evidence indicates that a legal guardian should be appointed, we will hold further benefits due until such time as a guardian of your estate is appointed and we will pay benefits to such guardian at that time. If any amount remains unpaid when you die, we will pay your estate.

Authority

The *policyholder* delegates to us and agrees that we have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the *policy*. All determinations and interpretations made by us are conclusive and binding on all parties.

Filing a Claim

1. You must send us notice of the claim. We must have written notice of any insured loss within 30 days after it occurs, or as soon as reasonably possible. You can send the notice to our *home office*, to one of our regional group claims offices, or to one of our agents. We need enough information to identify you as a *covered person*.

2. Within 15 days after the date of your notice, we will send you certain claim forms. The forms must be completed and sent to our *home office* or to one of our regional group claims offices. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.

3. The time limit for filing a claim is 90 days after the end of the first month (or shorter period) for which we are liable.

4. To decide our liability, we may require:

- proof of benefits from other sources, and
- proof that you have applied for all benefits from other sources, and that you have furnished any proof required to get them.

Proof of Loss

Within 30 days of the start of your *disability*, you should give us proof that you are currently *disabled* and have been continuously *disabled* since your last day of *active work*. Proof must be given within 90 days after the end of your *qualifying period*. If proof of loss is first received by us more than 180 days after the end of the *qualifying period*, your Schedule Amount will be reduced by 30%.

Continuing proof of *disability* must be given as often as we may reasonably require. Continuing proof must be given within 60 days of our request.

You must provide us with all of the information we specify as necessary to determine proof of loss and decide our liability. This may include but is not limited to medical records, hospital records, pharmacy records, test results, therapy and office notes, mental health progress notes, medical exams and consultations, tax returns, business records, Workers' Compensation records, payroll and attendance records, job descriptions, Social Security award and denial notices, and Social Security earnings records.

You must provide us with a written authorization allowing the sources of medical, vocational, occupational, financial, and governmental information to release documents to us which enables us to decide our liability. If you do not provide us with continuing proof of *disability* and the items and authorization necessary to allow us to determine our liability, we will not pay benefits.

Right to Examine or Interview

We may ask you to be examined as often as we require at any time we choose. We may require you to be interviewed by our authorized representative. We will pay third party charges for any independent medical exam or interview which we require. If you fail to attend or fully participate, we will not pay benefits.

Limit on Legal Action

No action at law or in equity may be brought against the *policy* until at least 60 days after you file proof of loss. No action can be brought after the applicable statute of limitations has expired, but, in any case, not after 3 years from the date of loss.

Review Procedure

You must request, in writing, a review of a denial of your claim within 180 days after you receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit written comments, documents, records and other information relating to your claim for benefits.

We will review your claim after receiving your request and send you a notice of our decision within 45 days after we receive your request, or within 90 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant provisions of the *policy*. We will also advise you of further review procedures, if any.

Incontestability

The validity of the *policy* cannot be contested after it has been in force for 2 years, except if premiums are not paid.

Any statement made by the *policyholder* or a *covered person* will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the *covered person* or the *beneficiary*.

No statement, except fraudulent misstatement, made by a *covered person* about insurability will be used to deny a claim for a loss incurred or *disability* starting after coverage has been in effect for 2 years.

No claim for loss starting 2 or more years after the *covered person's* effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Claims Experience

At the request of the employer, *policyholder*, or an *associated company*, we will provide a complete record of the claims experience incurred under the *policy*. This record will include all claims incurred for the lesser of the time since the *policy* was issued or last reissued. This record will be available immediately upon request made not less than 30 days before the date the premiums or *policy* may be amended.

GENERAL PROVISIONS

Entire Contract

The *policy* and the *policyholder's* application attached to it, and individual applications, if any, of the *covered person* are the entire contract. Any statement made by you or the *policyholder* is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you or your personal representative.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary, but not beyond 3 years before the date the error was found. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about you or the *policyholder's* plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

Certificates

We will send certificates to the *policyholder* to give to each *covered person*. The certificate will state the insurance to which the person is entitled. It does not change the provisions of the *policy*.

Workers' Compensation

The *policy* is not in place of, and does not affect any state's requirements for coverage by Workers' Compensation insurance.

Agency

Neither the *policyholder*, any employer, any *associated company*, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

GENERAL PROVISIONS (continued)

Fraud

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the *policy* and recovery of any amounts we have paid.

SUMMARY PLAN DESCRIPTION

This Summary Plan Description is issued to you in compliance with the Employee Retirement Income Security Act of 1974 (ERISA). Included within this document is your Certificate of Insurance, issued by Union Security Insurance Company in compliance with state law. Your Summary Plan Description does not replace or modify the Master Policy issued by Union Security Insurance Company in any way. The Master Policy is the contract which sets forth the terms and conditions of the benefits the Plan Sponsor chose to provide in its welfare benefit plan. The Master Policy may be amended at any time by agreement between the Plan Sponsor and Union Security Insurance Company. The Master Policy may be terminated at any time by the Plan Sponsor or may be terminated by Union Security Insurance Company for non-payment of premium or for failure to meet the Master Policy's minimum participation requirements. The Plan Administrator has the obligation to prepare, issue, amend and file the Summary Plan Description (SPD) and is solely responsible for its contents.

GENERAL ADMINISTRATIVE PROVISIONS

Name of the Plan: The City of Falls Church

Plan Sponsor: The City of Falls Church
300 Park Avenue
Falls Church, VA 22046
(703) 248-5128

Employer I.D. Number: EIN 546001271

Type of Plan: An employee welfare plan providing benefits for:

Long Term Disability Insurance

Plan Number: PN501 unless another number is assigned by the employer, the Plan Administrator, or on any Form 5500 filed for the Plan.

Effective Date: The plan, as described in this SPD, became effective on July 1, 2002.

Plan Administrator: The City of Falls Church
Human Resource Specialist
300 Park Avenue
Falls Church, VA 22046
(703) 248-5128

Type of Administration: This plan is insured by a contract with Union Security Insurance Company.

Amendment or Termination of Plan: This plan may be amended or terminated at any time by the Plan Sponsor.

Agent for Service of Legal Process: The City of Falls Church
Human Resource Specialist
300 Park Avenue
Falls Church, VA 22046
(703) 248-5128

Plan Records: The fiscal records for the plan are kept on a policy year basis ending each June 30.

Cost of Benefits: The premiums for the Long Term Disability Insurance plan are paid for entirely by the Plan Sponsor.

Your plan includes: Long Term Disability Insurance

The benefits, limitations and exclusions are described in the Certificate, which is found within this Description.

STATEMENT OF ERISA RIGHTS

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

(i) Examine, without charge at the plan administrator's office and at other locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents which the plan filed with the U.S. Department of Labor, such as annual reports and plan descriptions.

(ii) Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

(iii) Receive a summary of the plan's annual financial report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate our plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for welfare benefits is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request certain materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court may decide who should pay court

costs and legal fees. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CLAIMS PROCEDURE

The following procedures apply to the extent benefits under your employee benefit plan are insured under a contract issued by Union Security Insurance Company.

PRESENTING A CLAIM

Contact your plan administrator, who will advise you of any forms which are required. These forms should be returned to the Plan Administrator after completion. This Administrator will review them, complete any information concerning eligibility and forward them to Union Security Insurance Company. Time limits for filing the claim and other requirements for notice and proof of loss may be found under the heading, "Filing A Claim".

NOTIFICATION OF DECISION

A decision will be made within 45 working days after receipt by Union Security Insurance Company of a properly executed, complete proof of loss unless circumstances beyond the control of the Plan require an extension of time for processing the claim. Such an extension of time may not exceed 30 additional days unless circumstances beyond the control of the Plan require a second extension, not to exceed an additional 30 days. Complete proof of loss includes any investigation by Union Security Insurance Company necessary to determine its liability under the Group Policy. If the claim is denied in whole or in part, Union Security Insurance Company will provide written notice to the Plan Administrator for delivery to you. The written notice will contain:

1. The specific reason or reasons for the denial;

2. Specific reference to pertinent provisions of the policy upon which the decision is based;

3. A description of any additional material or information needed to perfect the claim and an explanation of why it is necessary;

4. An explanation of the plan's claim review procedure.

AUTHORITY

The Plan Sponsor delegates to Union Security Insurance Company and agrees that Union Security Insurance Company has the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the Policy. All determinations and interpretations made by Union Security Insurance Company are conclusive and binding on all parties.

REVIEW PROCEDURE

You are entitled to a full and fair review of denial of claim. You may make a request to the Plan Administrator or appropriate named fiduciary, if other than the Plan Administrator. The procedure is as follows:

1. The request for review must be in writing and made within 180 days of receipt of written notice of denial;

2. You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits. You have the right to review copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making our decision to deny your claim. You have the right to submit issues and comments in writing, along with additional documents, records, and other information relating to your claim;

3. The Plan Administrator will forward the request to Union Security Insurance Company;

4. Union Security Insurance Company will make a decision upon review within 45 days after receipt of the request unless special circumstances require an extension of time for processing in which case the time limit shall not be later than 90 days after receipt. The decision or review will be in writing, include the specific reasons for the decision and specific references to the pertinent plan provisions on which the decision is

based and be furnished either directly to you or to the Plan Administrator for delivery to you.